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A SURVIVALIST GUIDE TO TEACHING ERISA[†]

DAVID M. FRANKFORD* AND SARA ROSENBAUM**

It is certainly not news that teaching ERISA¹ is one of the most challenging tasks that a health law professor faces. Each year when your authors perform this labor of love-hate, particularly when we begin to teach ERISA preemption, we exchange emails describing how our students look like deer frozen in the headlights of an oncoming car. We write this article to describe how we try to move them out of those lights and into safety.

Teaching ERISA is so hard because, quite frankly, nothing makes sense. The doctrine itself reveals the basic contradiction of relying primarily on a voluntary, employer-provided health insurance system to insure approximately sixty percent of our nonelderly population² while simultaneously imposing regulation on that system and somehow trying to avoid its demise. The ACA did almost nothing to address this dilemma and so our society, including our legal regime, remains stuck between a rock and a hard place. In teaching this contradiction, we have found that the best one can do is to teach the students the arguments that can be made with regard to particular issues and the policy choices that are available to resolve them. We ask that students not kill the messengers.

[†] We are grateful to the decades of students who have had to endure not only the insanity of ERISA doctrine but our teaching thereof.

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1. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified in part at 29 U.S.C. ch. 18).

2. *Employer-Sponsored Coverage Rates for the Nonelderly by Age*, KAISER FAMILY FOUNDATION, <http://kff.org/other/state-indicator/rate-by-age-2/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22all%22:%7B%7D%7D%7D> [https://perma.cc/92RQ-EV9PJ].

I. THE BASIC PRINCIPLES OF INCOHERENCE

It is important from the start that students understand two fundamental points. First, they must grasp that ERISA governs all private employer-sponsored health insurance (other than church plans) while it simultaneously does not require that employers offer any health insurance at all. Students often find this to be confusing—who wouldn't? Some think that employers can opt into ERISA, that there are two kinds of employer-sponsored insurance—one flavor covered by ERISA, one not. To dispel any such confusion, it is crucial to stress the subjunctive: *if* a private employer of any size offers health insurance, then that plan is governed by ERISA.

The significance of this subjunctive looms large for ERISA doctrine, for it is the root of the settlor function: “*if* the plan sponsor promises this, then” Protected above all else, therefore, is the settlor’s unfettered right over plan design—leaving aside any mandate imposed by ERISA itself, whether directly or incorporated by reference, or by state law where relevant: “*if* the plan sponsor promises this, then it is promised unless the plan sponsor decides to change plan design, in which case it is then ‘un-promised.’”³ Our students advance out of the first year only by learning the converse in contracts: “If A promises something and then fails to perform that promise, then A stands in breach of contract.” Do you mean that ERISA displaces ordinary notions of contract? Yes, Virginia, there is no Santa Claus.⁴

Second, students need to understand that ERISA’s application to health care is a misfit, stemming from the fact that employer-sponsored health benefit plans were suddenly—and without much reflection or discussion—grafted onto legislation designed to shore up employer-provided pensions. The problem is that pension plans and health benefit plans simply are different animals. Health insurance protects against a vast array of illnesses, each of which may likewise command a large number of treatment options, with the result that the number of contingencies leading to claims, and indeed the number of those claims and the variation among the magnitude of loss for each one, far eclipse the contingencies leading to payouts from a pension system and the numbers and amounts of those payouts.

The result is that the scope of discretion with regard to pensions and health insurance differs greatly. Pension administration requires the exercise of discretion with regard to contributions, investments, and distributions—a fairly limited universe. The latter, in particular, is much more circumscribed in pension administration than in the administration of health insurance. Pension benefits are usually payable upon retirement or death and in the form of a

3. See the discussion below of *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991), *infra* note 10.

4. See *Yes, Virginia, There Is a Santa Claus*, NEWSEUM, <http://www.newseum.org/exhibits/online/yes-virginia/> [<https://perma.cc/ABN9-AEB2>].

lump-sum distribution or annuity benefit, while the reasons for payment of a health insurance benefit are as vast as the number of stars in the sky. Pension benefits can therefore be relatively fully described in legal language; by contrast, open-ended language—“medically reasonable and necessary”—must be used to define health insurance benefits. As a result, one can point to a relatively discrete set of organic documents that together comprise the pension “plan,” i.e., the contingencies that determine whether a benefit is due and its amount. By contrast, no set of documents so defines health insurance benefits. The plan is defined only in the course of its administration, which is spread among a wide array of functions that are often splintered among a large cast of characters: claims processing, utilization review, actuarial services, information technology services, behavioral health services, pharmacy benefit management services, and internal claims appeals, among others. Much of the ERISA doctrine depends on distinguishing between tasks that are discretionary—inside “the plan”—and those that are ministerial—outside “the plan.” Given that this discretion pervades the definition of health insurance benefits and ultimately reaches and potentially influences the very treatment decisions that health care providers may select—e.g., whether to manage a condition medically or perform surgery; whether to admit a high-risk pregnant patient to a hospital or manage her care at home; whether to provide treatment on an inpatient or outpatient basis—distinctions between “the plan” and the outside are mostly meaningless. Students in search of rational distinctions find none. Deer in the headlights.

As we will describe below, as the material progresses, students need to learn a third fundamental point. The rhetoric of ERISA promulgators—and still extant defenders against state encroachment⁵—is that ERISA provides comprehensive regulation of health benefits, thereby justifying and leading to vast preemption of state authority over employer plans. However, ERISA actually provides very little regulation, with the result that the vast preemption of state law leaves nothing but a federal vacuum. Even in the case of ERISA plans that involve the purchase of state-regulated group insurance coverage, the scope of preemption over rights and remedies is enormous. In the case of self-insured plans—which account for most workers covered by employer plans—the effects of preemption are truly breathtaking.

II. THE UNREAL SUBSTANCE OF ERISA

It is important to note that section 502 of ERISA creates an express cause of action for plan beneficiaries and participants (in contrast to, say, the PHSA,

5. See, e.g., *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936, 946 (2016).

the ACA, and the Medicaid statute).⁶ Moreover, we point out how limited the explicit monetary remedies are circumscribed to “benefits due,” omitting, most importantly, consequential damages available under state common law remedies, much less the penal damages often available under state law for bad faith breach of contract. Additionally, while the equitable remedies promised appear to be strong, they are quite limited, although *Cigna v. Amara*⁷ and subsequent cases⁸ perhaps signal that the courts will offer make-whole monetary remedies at least to some extent. Just with regard to remedies, the ERISA “contract” or “trust” is fairly hollow.

Indeed, it is ERISA’s imposition of a fiduciary obligation to protect plan members that appears most promising, although in the end, like ERISA’s promise of benefits due, it is a false promise. *Firestone*,⁹ of course, is the most important case. It is important to have the students lay out Justice O’Connor’s ode to the comprehensive, remedial nature of ERISA’s protection of plan members, and then follow that immediately with how her right hand took away what the left gave. What kind of trust is this? The students generally see quite readily how odd it is that a “fiduciary” gets to rewrite its own powers. Then, with *McGann*,¹⁰ what kind of contract is this? “I promise you benefits until I change this promise.” Students are generally fairly outraged at McGann’s plight, and this outrage can be channeled to show the perilous nature of our employer-provided health insurance system.

Moreover, isn’t it one thing for a plan sponsor to reserve a deferential standard of review to itself, while quite another for plan sponsors to write all sorts of medically unjustifiable practice guidelines directly into the plan and thereby effectively insulate themselves from liability for failure to provide benefits that appear to be promised by the plan?¹¹ Push it to the max:

Plan sponsor reserves the right to amend the plan at any time for any reason. We-Manage-You has the sole discretion to develop, interpret, and apply any guidelines and criteria used in determining whether services are medically reasonable and necessary. All such guidelines and criteria are hereby expressly incorporated into and made part of the plan and shall constitute the sole basis on which coverage is defined and upon which medical necessity determinations are made, and they supersede any and all criteria derived from

6. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 502, 88 Stat. 829, 891 (codified at 29 U.S.C. § 1132).

7. *Cigna Corp. v. Amara*, 563 U.S. 421, 441–42 (2011).

8. *See, e.g., Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 891–92 (7th Cir. 2013) (citing *Cigna* for the proposition that make-whole relief is available in appropriate circumstances).

9. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

10. *McGann v. H & H Music Co.*, 946 F.2d 401, 403, 405, 408 (5th Cir. 1991).

11. *See, e.g., Jones v. Kodak Med. Assistance Plan*, 169 F.3d 1287, 1292 (10th Cir. 1999).

any source other than this plan, including administrative or judicial decisions of any jurisdiction.

Finally, what kind of trust is this when fiduciaries *always* possess a conflict of interest,¹² and even get to make one, two, three—more?—honest, dumb mistakes because the courts fear that too onerous oversight will cause plan sponsors to abandon their plans?¹³ In all aspects of this doctrine, there is that subjunctive with a vengeance: “*if* an employer chooses to provide health insurance”

III. THE PREEMPTION OF SOMETHING BY NOTHING

“All deer are asked to proceed directly into the lion’s den.”

It is helpful to start teaching section 514 preemption by showing how its three subsections—the “relate to,” “saving” and “deemer” clauses—interact.¹⁴ We liken them to a funnel. If the top, the relate-to clause, is wide, then lots of state law goes into the preemption funnel. If the top is narrower, then more state law escapes. Isomorphically, if the saving clause is wide, then plenty of state laws, *as applied to insured plans*, go out of the funnel. If both the relate-to and saving clauses are wide, then the only real bite of section 514 is the deemer clause, which means that state law is preempted only as to self-insured plans, a result that has no rationality at all but follows from the plain-meaning interpretation the Court initially gave to the relate-to¹⁵ and saving clauses¹⁶ in its initial forays into the thicket of section 514. This irrationality led to Justice Blackmun’s deadpanning in *MetLife*:

The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States’ lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.¹⁷

12. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 117 (2008).

13. *Conkright v. Frommert*, 559 U.S. 506, 517 (2010).

14. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, § 514, 88 Stat. 829, 897 (codified as amended at 29 U.S.C. § 1144).

15. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983).

16. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 744, 746 (1985).

17. *Id.* at 739–40. In dissent in *FMC Corp. v. Holliday*, Justice Stevens wrote:

From the standpoint of the beneficiaries of ERISA plans—who after all are the primary beneficiaries of the entire statutory program—there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward

That the Supreme Court got off on the wrong foot in interpreting the relate-to clause is easily demonstrated with a series of hypotheticals along the lines of the knee bone is connected to the shin bone, etc. What if Massachusetts taxes bed sheets? What about its licensure of doctors? Etc.? Why should a civil rights law such as the New York law at issue in *Shaw v. Delta Airlines*,¹⁸ whose purpose was to prevent discrimination based on pregnancy, ever be preempted on the grounds that ERISA allows employers doing business in New York to discriminate against pregnant women as a matter of plan discretion?

In this regard, *Travelers*¹⁹ both brought some degree of rationality to section 514 and made teaching ERISA preemption somewhat easier in that at least *something* seems to make sense. It is important to make two points about *Travelers*. First, the Court went functional, effectively applying something akin to conflict preemption in balancing the impact of state law on plan administration and structure against the nature of the state interest. Second, the Court did not cut back the preemptive force of section 514 to the subject matters actually covered by ERISA—reporting, disclosure, vesting, solvency, procedural rights like full and fair hearings, and fiduciary duties—because it felt hemmed in by legislative history indicating that section 514 reaches beyond those core concerns.²⁰ The latter would have fully brought rationality to the scope of section 514—but see *Pilot Life*²¹ discussed immediately below—because state law would be displaced only when necessary for federal law to be supreme instead of preempting state law even when there is no federal law. The ERISA vacuum raises its ugly head.

Well, at least that's how we've taught it until last year's inane decision in *Gobeille*, in which the Court held that section 514 preempts Vermont's reporting requirement for its all-payer claims database ("APCD").²² We could write at length about this decision—and have²³—but (only!) six points will do

English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

FMC Corp. v. Holliday, 498 U.S. 52, 66 (1990) (Stevens, J., dissenting).

18. *Shaw*, 463 U.S. at 88.

19. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

20. *Id.* at 656–57.

21. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

22. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936, 947 (2016).

23. See SARA ROSENBAUM & DAVID M. FRANKFORD, LAW AND THE AMERICAN HEALTH CARE SYSTEM SECOND EDITION, 2012–2016 UPDATE, 93–103, <http://www.westacademic.com/Util/Downloads/FileDownload.aspx?NSIID=1382804> [https://perma.cc/CD6J-UEEU]. Given space limitations, we greatly simplify. In particular, one can read the various opinions as a holding that Congress has occupied the field with regard to “reporting.” However, that characterization of the

here. First, the Court effectively went back to a plain meaning interpretation, rightly abandoned in *Travelers*, holding that “reporting” is “reporting” in that it ignored the fact that the reporting to DOL under ERISA concerns plan solvency and does not remotely touch on the type of reporting required to create an APCD. There simply is no federal subject matter involved and the reasoning in *Travelers* dictates a contrary result. Second, the Court’s holding is limited to a core concern, “reporting,” and therefore does not represent an abandonment of the use of the balancing set up by *Travelers* to determine outcomes outside of those core interests. Third, the Court decided that plans are burdened without any factual record at all. What is this, judicial notice? Burden is something that must be proven, not just assumed. Fourth, national uniformity in the administration of multistate plans is a myth, a national legend used for political purposes to defend exemption from state law. Fifth, how could the Court state that DOL “may” have power to collect the data to create APCDs while simultaneously holding that state authority is preempted? Regardless of the flavor of preemption applied—field, conflict, some special ERISA variant—state power can be superseded *only* if federal power exists. Sixth, the Court may simply be wrong that federal power “may” exist because it may well not.

Gobeille’s introduction of a new irrationality into ERISA preemption doctrine would be more troubling if it represented a post-*Travelers* return to irrationality but, unfortunately, irrationality never left at all, which brings us to the saving clause. As with interpretation of the relate-to clause, the Court initially took a plain-meaning approach to the saving clause. Of course, Justice Blackmun seriously muddled things when he noted that “[t]his common-sense view of the matter” was “strongly support[ed]” by the tripart test of *McCarran-Ferguson*.²⁴ It took the Court almost two decades to clean up the problem created by its reliance on the *McCarran-Ferguson* test. In *Kentucky Association of Health Plans v. Miller*, the Justices told us that those factors do not all have to be satisfied and the heart of the matter is whether the state law at issue regulates risk pooling.²⁵

Well, almost. In his opinion for a unanimous Court, Justice Scalia walked up to the point that state regulation of insurance is about risk pooling alone because, after all, insurance *is* risk pooling—he said as much—but then he stepped back from that logically compelled conclusion and reinserted the requirement that to be saved, a state law must be aimed at insurers. Why should the identity of the entity being regulated matter? In regulating insurance, states regulate contractual relationships and there is no rhyme or

decision begs the question because one still must define what is meant by “reporting.” We urge upon you the longer version in the Update.

24. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 740, 742 (1985).

25. *See Ky. Assoc. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 339–42 (2003).

reason to require them to focus a law on one side of the contract or the other. And why insist on a requirement that is a mere formalism easily evaded by good drafting?²⁶ The late Justice Scalia surely understood that he wrote an opinion that is internally incoherent. Why did he do that? Of course, it is always perilous to psychoanalyze opinions but we suspect that the Court's backing away from going fully functional in interpreting the saving clause—i.e., making parallel the post-*Travelers*, post-*Kentucky Association* analysis of the relate-to and saving clauses, which, after all, are supposed to be construed *in pari materia*—has something to do with *Pilot Life*.²⁷

The most important task in teaching *Pilot Life* is to make sure that the students understand that Justice O'Connor almost just slid in an independent basis for preemption, the complete preemption of state law remedies by section 502. We take them through the opinion, in which we seem to be discussing section 514 preemption and then almost as a sleight of hand Justice O'Connor, seemingly sensing the shaky ground she is on, shifted the subject to a discussion of section 502:

Because in this case, the state cause of action seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan, our understanding of the saving clause *must* be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a).²⁸

We suppose that section 502 *must* have the gravitational pull of a planet, operating as some sort of last line of defense against an interpretation of ERISA—whether in the context of insured or self-insured plans—that would retain employer accountability under state law for negligence or outright bad faith in connection with the administration of benefits to which their employees are entitled.

There are almost boundless opportunities to beat up on this opinion, indicated in part by the number of times words like “surely,” “certainly,” and “undoubtedly” appear, indicators that nothing is sure, certain, or undoubted—always worth pointing out to law students. However, to keep discussion manageable here, we'll focus on two issues. First, does Mississippi's cause of action for bad faith breach of contract relate to an employee benefit plan? Second, is this cause of action saved as state regulation of insurance? Put differently, can *Pilot Life* withstand the reinvention of section 514 wrought by *Travelers* and *Kentucky Association* as balancing states' long-standing interest in regulating insurance—the risk-pooling function—against ERISA's supposed

26. The following hypothetical law supposedly regulates insurers: “No insurer operating in this state shall . . .” The following hypothetical law supposedly does not: “No licensed provider in this state shall execute a contract with any insurer that . . .”

27. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

28. *Id.* at 51–52 (emphasis added).

regulation of the structure and administration of employer-provided insurance, which we've seen is nothing like that described in Justice O'Connor's words, "the detailed provisions of [ERISA] § 502(a) [which] set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans."²⁹ Put differently still, did Justice Scalia write an internally inconsistent opinion in *Kentucky Association* to avoid overruling *Pilot Life*—and while we're at it, is perhaps the Court avoiding overturning decades of rulings under sections 502 and 514 by expanding, post-*Amara*, the availability of make-whole equitable remedies? Very interesting.

Regarding the post-*Travelers* interpretation of section 514, Justice O'Connor's opinion itself answers the question as she carefully traced the law of bad faith breach back to 1915, numerous subsequent decisions and ultimately "firmly planted in the general principles of Mississippi tort and contract law."³⁰ Sounds pretty traditional, huh, going back into the writ system of medieval England? And where is the federal interest asserted in ERISA? Mandating plan benefits and administration? If the latter is true of Mississippi's bad faith breach common law remedy, then any law enforcing contractual terms would likewise mandate plan benefits and administration. Thus, once the doctrine has moved away from that road-to-everywhere interpretation given to section 514 in *Shaw*, this part of *Pilot Life* must fall.

Regarding the post-*Kentucky Association* interpretation of the saving clause, here's the sum total of the Court's reasoning regarding risk pooling: "Unlike the mandated-benefits law at issue in *Metropolitan Life*, the Mississippi common law of bad faith does not effect a spreading of policyholder risk."³¹ Aside from the fact that it's always good to ask students whether something is a step in the reasoning or the conclusion, substantively, regulating bad faith interpretations of insurance contracts doesn't affect risk spreading? Really?

Ask the students to compare two policies. One says, "Policyholder bears the risk that insurer will act in bad faith in interpreting the provisions of this policy." The other: "Insurer bears the risk that it will act in bad faith in interpreting the provisions of this policy." Clearly, the same policy, right? Isn't part of the risk insured against in an insurance contract that insurers will act in bad faith, as written into the contract by the state's boundary laws regulating insurance? (By the way, there's that inside-outside distinction again: are the penal damages for bad faith breach "inside" or "outside" "the plan" because they are explicitly stated or implied by state law, respectively?). Hence, Justice

29. *Id.* at 54.

30. *Id.* at 49–50.

31. *Id.* at 50.

O'Connor's only escape from the conclusion that Mississippi is regulating insurance is to return to the old saw that state law regulating insurance doesn't regulate insurers. Might it be that Justice Scalia hung onto that thin reed in *Kentucky Association* to avoid overruling decades of precedent?

IV. QUALITY MATTERS

To understand, finally, that the Court may be making up for the continued deficiency of its preemption analysis by expanding the monetary damages available under section 502's equitable remedies, we first need to address the lack of quality of its opinions addressing the preemption of state law regulation of quality in the form of remedies for malpractice. Is the Court creeping toward consequential damages as a federal remedy while retaining the creepy—(sorry, we're writing around the time of Halloween!)—preemption analysis?

Before diving into the preemption cases it is crucial to set the framework by reminding the students how the imposition of malpractice liability on managed care organizations ("MCOs") grew out of an extension of institutional liability for hospitals to managed care. Cases like *Darling*,³² imposing corporate liability against hospitals for their acts, and cases like *Thompson v. Nason Hospital*³³ and *Jackson v. Powell*,³⁴ holding hospitals liable for actual or apparent agency and non-delegable duties, were extended to MCOs for acts like lack of oversight of their doctors,³⁵ inadequate construction of networks,³⁶ improper credentialing,³⁷ improper financial incentives,³⁸ errors in utilization review,³⁹ and the creation of inadequate practice guidelines or protocols.⁴⁰ Like in the hospital cases, courts in the actions against MCOs have to sort out who is responsible for harm to a patient. Is it a doctor who simply botches care, is it the MCO that has structured the process and outcome of care, or is it some combination of the two?

32. *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 260 (Ill. 1965).

33. *Thompson v. Nason Hosp.*, 591 A.2d 703, 707–08 (Pa. 1991).

34. *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987).

35. *See, e.g., Shannon v. McNulty*, 718 A.2d 828, 836 (Pa. Super. Ct. 1998); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1231 (Pa. Super. Ct. 1988).

36. *See, e.g., Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119, 1134 (Ill. 2000).

37. *See, e.g., Petrovich v. Share Health Plan of Ill.*, 719 N.E.2d 756 (Ill. 1999); *Pagarigan v. Aetna U.S. Healthcare of Cal., Inc.*, No. B167722, 2005 WL 2742807, at *7 (Cal. Ct. App. Oct. 25, 2005); *McClellan v. Health Maint. Org. of Pa.*, 604 A.2d 1053, 1058 (Pa. Super. Ct. 1992); *Boyd*, 547 A.2d at 1231, 1233–34.

38. *See, e.g., Pagarigan*, 2005 WL 2742807, at *6; *Dunn v. Praiss*, 606 A.2d 862, 864 (N.J. Super. App. Div. 1992); *Boyd*, 547 A.2d at 1234.

39. *See, e.g., McEvoy v. Grp. Health Coop. of Eau Claire*, 570 N.W.2d 397 (Wis. 1997); *Wickline v. State*, 239 Cal. App. 810 (Cal. Ct. App. 1986).

40. *See, e.g., McClellan*, 604 A.2d at 1059; *Boyd*, 547 A.2d at 1229.

In some cases, it is arguably clear where cause lay. An impaired surgeon who can't see the lines drawn on a patient and operates on the wrong side has caused the harm. (But even here, couldn't a proper process of care have prevented such a blunder, and where were the nurses?). A Medicaid MCO that has assigned over 4500 children to a solo-practice pediatrician, well over the number prescribed by Medicaid regulations and over twice as many allowed in the contract between the MCO and that state Medicaid agency, has caused the permanent disability of an infant due to untreated meningitis when a frantic mother's calls get ignored or she is advised to give castor oil to the baby.⁴¹ (But even here, why did the doctor allow himself to get so overloaded?).

However, almost all the cases, if not all, are in that middle ground in which the harm has been caused both by the structure and process of care and the actions or omissions of individuals providing care within that structure and process. Take the famous case of *Wickline*, in which the court absolved Medi-Cal of liability because the treating physicians did not sufficiently protest the utilization review decision to limit further hospitalization to fewer days than requested.⁴² The process involved a breakdown in communication, which was jointly created by (1) the manner in which Medi-Cal organized its review process—the relevant form, the MC-180, was inadequately designed to convey the information that the reviewer, Dr. Glassman, needed; (2) the manner in which Dr. Glassman, his supervisor, and the on-site nurse, Nurse Futerman, conducted the process—the MC-180 was unsigned, crucial fields were left blank, and Dr. Glassman made his decision without looking at any of the information obtained in the initial authorization of the hospital stay and before he had even seen the MC-180; and (3) the action of Wickline's attending physicians in authorizing the discharge, the manner in which their decisions were made—which were a mixture of medical considerations in that her condition had not deteriorated during the four days prior to discharge—as well as their failure to press their view in the review system, an omission which in turn may have been induced by Medi-Cal's repeated denials, making argument futile.⁴³ Dr. Glassman, a general surgeon long out of practice and possessing no knowledge of vascular surgery, only wanted to know whether Wickline had a fever, could ambulate, defecate, and eat properly.⁴⁴ None of this was in the least relevant to the question regarding the risk of another clot forming at the site of the synthetic graft, something a vascular surgeon would have readily perceived. Dr. Glassman was as qualified to make that decision as you or we. What caused the loss of Wickline's leg? *All of it.*

41. *Jones*, 730 N.E.2d at 1123.

42. *See Wickline*, 239 Cal. Rptr. at 811, 819.

43. *See id.* at 814–15.

44. *Id.* at 815.

In contrast to this inherent messiness of health care, in which decision making is splintered in a million different directions, preemption analysis is dichotomous. Malpractice liability against the MCO, providers within its network, or both either relates to a benefit plan or it does not. The cause of action either arises under ERISA because it is a suit for benefits due, and therefore within complete preemption doctrine of *Pilot Life*, or it is not. How does one cram the mayhem of health care into the simple categories of ERISA preemption: plan design/administration/structure/suit for benefits due/action for breach of ERISA fiduciary duties? Only by drawing distinctions that cannot hold water.

Take *Corcoran*, in which the parties argued furiously whether the harm was caused by a “medical decision” or a “benefit determination,” and the court accepted the validity of the distinction and ultimately ruled that the case involved a medical decision incident to a benefit determination.⁴⁵ Or take *Pegram*, in which the Court distinguished among “pure eligibility,” “treatment decisions,” and “mixed eligibility-treatment” decisions.⁴⁶ Seriously? In some long ago health care world, aside from the traditional HMOs like Kaiser and Group Health, health care was financed on the one side, and delivered on the other, and never the twain shall meet. Even though this separation was always a fantasy to some extent, the very idea of managed care has been to infuse medical decision making with financial considerations, and so how can we have a workable distinction between “medical judgment” and “benefit administration,” or among “pure eligibility,” “pure treatment” and “mixed eligibility-treatment” decisions? Of course, the entire need to maintain such distinctions is driven by the basic nonsense of the relate-to-clause doctrine and the need to decide whether the cause of harm is “inside” “the plan”—“benefit administration” aka “pure eligibility”—or “outside”—“medical judgment” aka “pure treatment.” (Wait a minute, does that mean that “mixed eligibility-treatment” decisions are somewhere in suspended animation?). Moreover, there remains *Pilot Life* and the analogous search to distinguish remedies “arising under ERISA” from remedies that do not. Inside-outside, yet again.

As we step through the cases, we play with the identity of the decision-makers and the structure of the decision-making process to show how managed care wears two hats, blending together plan design/administration/structure/suit for benefits and due/action for breach of ERISA fiduciary duties (hereinafter “plan design etc.”), such that it would seem that a plaintiff could seemingly never avoid complete preemption. But see *Dukes v. U.S. Healthcare*,⁴⁷

45. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329–31 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

46. See *Pegram v. Herdrich*, 530 U.S. 211, 230–31 (2000).

47. *Dukes v. U.S. Healthcare Inc.*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995).

discussed below. Suppose the plaintiff in *Corcoran* had visited her obstetrician and he had decided not to hospitalize her. Medical decision and not plan design etc.? Seems so. But no cause of action against the MCO because it's utterly uninvolved. Oh well. Suppose instead that the obstetrician is subject to a withhold dependent on the number of hospitalizations per year. Medical decision and not plan design etc.? *Hmm*. Suppose in addition that profiling is used and the network is constructed in part based on the number of hospitalizations per obstetrician per year. Medical decision and not plan design etc.? *Hmmm*. Suppose that the obstetrician is following a practice guideline created by the plan. Medical decision and not plan design etc.? *Hmmmm*. When the obstetrician makes his decision within these parameters, is the situation any different than that in the actual case, in which the plan made a direct, explicit utilization review decision to substitute a home nursing benefit for an inpatient admission? *Hmmmmm*. Don't plan administrators make medical decisions? Don't they make benefit determinations? Don't physicians within these plans make medical decisions? Don't they make benefit determinations?

In teaching *Corcoran*, it is worth pointing out that the case was decided before *Travelers* and to ask if that makes a difference. Does control over utilization directly or indirectly through all the tools of managed care affect plan structure and administration? Yes, you've just demonstrated that. But hasn't *Travelers* put state regulation of quality strongly within the you-better-show-me-the-Congressional-intent-to-displace-state-law side of the world, other than some state interest bumping up against some *Gobeille*-esque core concern? Yes. So, which way does *Travelers* point? Both ways at once? Now what? However, given *Pilot Life*, does any of this even matter? No. See *Aetna Health, Inc. v. Davila*.⁴⁸

Before proceeding to *Davila*'s hammer, we explore *Pegram* a bit to set the stage. First, help the students see that the result in *Pegram* was almost predetermined, for if the Court had held that "mixed eligibility-treatment" decisions were the acts of ERISA fiduciaries then the federal courts would have been swamped with a flood of "fiduciary malpractice" litigation, a prospect that the Court regarded with barely-concealed horror and could not imagine that Congress intended.⁴⁹ Then, ask what does *Pegram* imply about the result in *Corcoran*? Well, the decision in *Corcoran* was mixed, was it not? Therefore, it falls outside of ERISA, yes? Then *Pegram* overrules *Corcoran*, right, and state malpractice law should not be preempted? What would be the effect of having it both ways that "mixed eligibility-treatment" decisions fall outside of ERISA but state law is nonetheless preempted because of *Pilot Life*? *The ERISA Vacuum*.

48. *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

49. See *Pegram*, 530 U.S. at 235–37.

At this point, there is relatively little that needs to be taught with regard to *Davila* except to ask, “Well, what about *Pegram*?” Justice Thomas answered that MCOs are administrators, in ERISA talk, who are necessarily ERISA fiduciaries, and therefore any challenges to their actions must be brought under section 502.⁵⁰ See *Pilot Life*. It’s as simple as that. Really?

So, what’s a plaintiff to do when trying to assert liability against an HMO? First, a plaintiff could sue the HMO as a fiduciary under section 502, taking advantage of the window *Amara* has opened to obtaining monetary damages as a form of equitable relief. Concurring in *Davila* because that result was “consistent with our governing case law on ERISA’s preemptive scope”⁵¹—i.e., refusing to overrule *Pilot Life* and its numerous progeny—Justice Ginsburg, writing for herself and Justice Breyer, noted that “‘Congress . . . intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief.’ I anticipate that Congress, or this Court, will one day so confirm.”⁵² A few years later, with *Amara*, the Court has started down that path, to cure at least in part the “‘regulatory vacuum’ [that] exists . . . [because] . . . ‘state law remedies are preempted but very few federal substitutes are provided.’”⁵³

Second, plaintiff can sue the HMO and hope that a court will buy its argument that the case is not about “benefits due” but about “medical malpractice”—“quality”—outside of the scope of section 502.⁵⁴ Why? “The statute simply says nothing about the quality of benefits received. . . . Nor does anything in the legislative history, structure, or purpose of ERISA suggest that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice.”⁵⁵ And, as Justice Thomas told us in *Davila*, state malpractice actions brought because of actions by physicians are distinguishable from actions brought against HMOs acting as ERISA fiduciaries, and that’s why *Pegram* could be distinguished from *Davila*.

Make sense? No. Arbitrary? Yes. State of the law? Yes.

The basic incoherence of the doctrine, the messiness of the delivery of health care itself, made exponentially more complicated by fusing delivery with management, itself organizationally extremely complex, lead to the distinctions without meaning we have discussed and indeterminate results. The managed care egg simply cannot be unscrambled and given the basic

50. See *Aetna Health*, 542 U.S. at 220–21; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

51. *Aetna Health*, 542 U.S. at 222.

52. *Id.* at 224 (internal citation omitted).

53. *Id.* at 222.

54. See, e.g., *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995).

55. *Id.* at 357.

conceptual incoherence of what a “plan” consists of and what falls outside of “the plan,” the result is simply a mess. Clearly, if the plan administrator makes an across-the-board decision to shape benefits under plan design—e.g., exclude all coverage for speech therapy that is not restorative but just habilitative—ERISA preempts a negligence action arising out of that decision and brought under state law. The key question is to decide whether a decision constitutes plan design. Similarly, if a decision is characterized as part of plan administration performed by one of the number of entities in the managed-care food chain, then a negligence action arising out of that decision is also preempted. However, as we have seen in these cases, the characterization question is by no means clear cut. *Dukes* leaves us with the distinction between decisions relating to the “quality” of treatment itself, which are not preempted, and decisions relating to plan design and administration, which are preempted, but, as should be clear by now, many decisions affect both quality and finance simultaneously.

This conceptual problem also intersects with the state-law doctrinal elements that a plaintiff must satisfy to bring a state-law negligence action against an entity other than the doctor who ultimately is responsible for treatment. You have probably realized by now that a plaintiff has a greater possibility of imposing vicarious liability against an actor in the managed-care food chain if that actor was more greatly involved in some manner in a decision directly connected with treatment. However, the dictates of state law, combined with the doctrine regarding ERISA preemption, puts the plaintiff between a rock and a hard place because the stronger the claim for assigning responsibility up the food chain, the greater the chance that the state law will be preempted.

In the end, the middle ground is simply far too vast. Network formation and administration are extremely complicated, and the question of the manner in which these aspects affect a particular decision in a particular case is always multifaceted. Isn’t assembling an incompetent network directly parallel to a hospital failing to select its medical staff with reasonable care? Why is one type of misconduct classified as plan design or administration while the other is corporate medical negligence? Think about the layer upon layer of contracting parties that exist in many if not most managed care networks. At any layer, financial incentives may be involved, guidelines created and deployed, providers profiled, providers selected and deselected, ongoing care supervised to differing degrees and among various parties, pay-for-performance imposed, quality reporting used, and so on, and so on, and so on.

Suppose a plaintiff can link an adverse event to some of these actions as influencing the treatment provided or not provided. Imposition under state law of vicarious or corporate liability is totally fact dependent, sensitive to the degree to which there was actual control of the treating physician, whether apparent authority was conveyed to the patient, or whether corporate

responsibility should be imposed for the situation created by some entity in the managed-care food chain. Indeed, because the structures of these layer cakes are so variable, the question whether there is “any there, there” up above in the food chain—any sort of institutionalization that we can say makes appropriate the analogy of imposing vicarious or corporate liability in hospitals—is enormously fact-sensitive. The same is true, then, whether a claim can be characterized as involving “quality” or “benefit determination.” Distinctions regarding what it is “inside” or “outside” “the plan” are vapid, as are those that attempt to separate remedies arising under section 502 from those that do not. The result is a total zoo.

CONCLUDING MATTERS

And so, we’ve come to the end of the matter. Perhaps the deer aren’t out of the headlights but at least they understand better where they are and that they have the entire legal community to keep them company in the blinding glare. As Alice might have described ERISA doctrine: “If I had a world of my own, everything would be nonsense. Nothing would be what it is, because everything would be what it isn’t. And contrary wise, what is, it wouldn’t be. And what it wouldn’t be, it would. You see?”⁵⁶ In the end, as in the beginning, we ask that students—readers more generally—please do not kill the messengers.

56. ALICE IN WONDERLAND (Disney Pictures 1951).